

## Patient Demographics

Patient's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best phone number to reach you (\_\_\_\_\_) \_\_\_\_\_ 2<sup>nd</sup> best (\_\_\_\_\_) \_\_\_\_\_

Best E-mail address to reach you \_\_\_\_\_

Patient's employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's address \_\_\_\_\_ City \_\_\_\_\_

Sex: ( ) Male ( ) Female      Date of birth \_\_\_\_\_      Age \_\_\_\_\_

Marital status ( ) Single ( ) Married ( ) Divorced ( ) Widowed    SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's driver's license # \_\_\_\_\_

Primary care physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### **Parent/Spouse/Guardian Information**

Who May we contact in case of an emergency or if we have to change an appointment and cannot reach you?

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best phone number to reach them (\_\_\_\_\_) \_\_\_\_\_ 2<sup>nd</sup> best (\_\_\_\_\_) \_\_\_\_\_

Who referred you or how did you find out about us? \_\_\_\_\_

Where did you find our contact information? \_\_\_\_\_

Purpose of visit \_\_\_\_\_

### **Primary Insurance**

Insurance company \_\_\_\_\_ Policy/Cert # \_\_\_\_\_

Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

### **Financial Agreement and Authorization For Treatment**

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for myself and my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown on statements are agreed to be correct and reasonable unless protested in writing within (30) thirty days of billing. In the event legal action should be necessary to collect unpaid balance due for medical services rendered to me or my family. In the account is referred to an attorney or collection agency, I will pay reasonable attorney's fees and collection expenses. I/We hereby agree to pay any and all charges that exceed or that are not covered by insurance. It is agreed that payments will not be delayed or withheld because of any insurance coverage or pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of his assignment is as valid as valid as the original)

#### **Authorization For Release of Information**

I hereby authorize Robert A. Norman, D.O. and Associates to release information requested by my insurance company or workers compensation carrier. I also authorize Robert A. Norman, D.O. and Associates to release information to any hospital or physician that I may be referred to by this office.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_